COMMUNITY
MEDICAL CENTERS

Medical Record#:_____

Patient Name (print): _____ Date of Birth:_____

Address (Street/City/State/Zip):_____

Telephone: _____SSN (last 4 digits): _____

1. **I hereby authorize that my protected health information be released from (select all facilities that apply):**
   - ☐ Community Regional Medical Center, 2823 Fresno Street, Fresno CA 93721
   - ☐ Clovis Community Medical Center, 2755 Herndon Avenue, Clovis CA 93611
   - ☐ Fresno Heart & Surgical Hospital, 15 E. Audubon Drive, Fresno CA 93720, includes Advanced Diagnostic Testing Center (ADTC)
   - ☐ Community Behavioral Health Center, 7171 N. Cedar Avenue, Fresno CA 93720
   - ☐ Community Cancer Institute, 785 North Medical Center Drive West, Clovis CA 93611
   - ☐ Community Subacute Transitional Care Center, 3003 N. Mariposa, Fresno CA 93703
   - ☐ Other (Please Specify): _____
2. **I hereby authorize the following persons or entities to receive my health information:**
   Name of Person/Entity: _____
   Address/City/State/Zip: _____
   Telephone: _____ Fax: _____
3. **Information to be Disclosed (tell us what information you need):**
   Information to be disclosed for the following date range _____to _____
   - ☐ Physician Report(s) and Test Result(s)
   - ☐ Radiology Report(s) Only
   - ☐ Radiology Image(s) – specify: ☐ X-Ray ☐ Ultrasound ☐ CT Scan ☐ MRI ☐ Mammography
   - ☐ Laboratory Test(s) Only
   - ☐ Complete Medical Record (all pages), excludes Radiology Images
   - ☐ Billing Records
   - ☐ Other (specify): _____
4. **Special Authorization (tell us if we have permission to release the following sensitive information):**
   I specifically authorize the release of the following information:
   - ☐ Human Immunodeficiency Virus (HIV) test results _____ (initial)
   - ☐ Alcohol/Drug Treatment Information _____ (initial)
   - ☐ Mental Health Treatment Information _____ (initial)
   - ☐ Genetic Test Results _____ (initial)

Note: A separate authorization is required to authorize the disclosure or use of psychotherapy notes, as defined in the federal regulations implementing the Health Insurance Portability and Accountability Act.

Health Information Management
Authorization to Release Protected Health Information

OFFICE USE ONLY Identification verified by (name): _____
Verified by (method): ☐ Photo ID ☐ Matching Signature
☐ Other: _____

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5. Purpose of Requested Use or Disclosure (tell us how you will use the records):

☐ Continuation of Medical Care ☐ Personal Use ☐ Insurance
☐ Other (please list): _____
Limitations, if any: _____
_____

6. Requested Format (ONLY check one):

☐ MyChart/Online Portal ☐ Compact Disc (CD) ☐ Paper Copy
☐ Email (encrypted), provide email address: _____
☐ Email (unencrypted, note – if you request information to be sent via email unencrypted there is an increased risk information could be read by an unauthorized third party), provide email address:
_____
☐ Other (must be agreed upon by the patient and provider): _____

7. Method of Release for paper copy or CD (ONLY check one):

☐ Mail ☐ Fax (paper only) ☐ Pick-Up (if applicable)

8. Expiration:

This authorization shall become effective immediately and shall remain in effect for (1) year from the date signed unless a different date is specified here: _____ (initial) _____

9. Your Rights:

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility benefits.
- I may inspect or obtain a copy of the health information I am being asked to allow the use or disclosure of.
- Information disclosed pursuant to this authorization could be redisclosed by the recipient. Such redisclosure is in some cases not prohibited by California law and may no longer be protected by federal confidentiality law (HIPAA). However, California law prohibits the person receiving my health information from making further disclosure of it unless another authorization for such disclosure is obtained from me or unless such disclosure is specifically required or permitted by law.
- My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.
- I revoke this Authorization for Release of Protected Health Information

  Date of Revocation: _____ Signature: _____
- I have a right to receive a copy of this authorization.
- ☐ If this box is checked, Community Medical Centers will receive compensation for the use or disclosure of my health information.

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10. Signature (as required by law):

_____ _____

Date/Time *Patient/Legal Representative* Signature*

If signed by other than patient, print name and indicate relationship to patient.

_____ _____

Relationship *Print Name*

Authorized legal representative signing for the patient must provide copies of the legal documents describing the personal representative's assignment of this authority.

_____ _____

Date/Time *Witness Signature # 1/Print Name/Title*

_____ _____

Date/Time *Witness Signature # 2/Print Name/Title*

(Witness Signature #2 required if patient marks with an "X".)

11. Interpreter Signature if applicable:

I have accurately and completely read the document to:

_____ in _____

Patient/Legal Representative Name *Language*

the patient's or legal representative's primary language. He/she understood all of the terms and conditions and acknowledged his/her agreement thereto by signing the document in my presence.

_____ _____

Date/Time *Interpreter Signature/Print Name/Title*